1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00567

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00570

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 22 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: R.D. 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lula; Middle: B.; Last: Asbury

4. DATE OF DEATH: Month: January; Day: 9; Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 19, 1919

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stephen Haynes

14. MOTHER'S MAIDEN NAME: Julia Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Address: Lloyd G. Asbury, Elkton, Md. R.D.5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO-RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH:

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): MYOCARDIAL INFARCTION — ? 30 min.

DUE TO (c): CORONARY ARTERY DISEASE — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Rolando A. Najera M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Rolando A. Najera

Address (Street, city, town, or county)

22. DATE SIGNED: 1/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/13/67

23c. NAME OF CEMETERY OR CREMATORY: McIntosh Cemetery

23d. LOCATION (City, town or county) (State): Clayhole, Kentucky

24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: JAN 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00568 00571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL SINGERLY AVE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHILDS
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva Middle: M. Last: Barrow

4. DATE OF DEATH: Month: January Day: 23 Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 12, 1895

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): RISING SUN, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS RINK

14. MOTHER'S MAIDEN NAME: SADIE KEITLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-54-9907

17. INFORMANT: RICHARD BARROW Address: CHILDS, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Urinary Obstruction — 2 weeks
DUE TO
(c): Carcinoma of the pancreas - metastatic 3 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____M, from causes and on the date stated above.

22a. SIGNATURE: John Doll. Najera M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/23/67

22c. PHYSICIAN'S NAME (Type): Rolando A. Najera, M.D.

22d. ADDRESS: 205 E. Main Street, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/26/1967

23c. NAME OF CEMETERY ~~OR CREMATORY~~: WEST NOTTINGHAM FRIENDS

23d. LOCATION (City or Town) COLORA (County) CECIL (State) MD.

24. FUNERAL DIRECTOR: RALPH M. REED Ralph M Reed ADDRESS: RISING SUN, MD.

25a. REC'D BY REGISTRAR DATE: JAN 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR-A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00569

CERTIFICATE OF DEATH

00572

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural- Rising Sun Maryland
   d. STREET ADDRESS: R.D.2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Annie — Middle: F. — Last: Bartlett

4. **DATE OF DEATH**: Month: Jan. — Doy: 29 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Oct. 11. 1890

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months: — Doys: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Grayson Co. Va

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Grubb Sr

14. MOTHER'S MAIDEN NAME: Frances Nichols

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. **INFORMANT** — Address: R. Emerson Bartlett - Rising Sun. R.D.2. Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for 1a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Brain Tumor operative hemiplegia 1943

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from January, 1960, to January, 1967, that (I) (~~we~~) last saw the deceased alive on January 29 1967, and that death occurred at Noon M, from causes and on the date stated above.

22a. SIGNATURE: J.B. Robinson M.D., M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 1/30/67

22c. PHYSICIAN'S NAME (Type): J.B. ROBINSON Pa Oxford

22d. ADDRESS: 133 Locust ST. Oxford, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 1. 1967

23c. NAME OF CEMETERY OR CREMATORY: Oxford Cemetery

23d. LOCATION (City or Town) (County) (State): Oxford, Chester, Pa

24. FUNERAL DIRECTOR: RALPH M. REED Ralph M Reed — ADDRESS: RISING SUN, MD

25a. REC'D BY REGISTRAR DATE: FEB 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00618 Item #7 Film #G385 2/20/67 pc 02087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Charlestown (Rural)
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural – Charlestown 07-1
d. STREET ADDRESS: R.D., Carpenters Point
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Bertha Middle V. Wolfe Last Biles
4. DATE OF DEATH: Month 1 Day 30 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XXX DIVORCED ☐
8. DATE OF BIRTH: 10-23-1891
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Tavern Owner
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elias L. Martin
14. MOTHER'S MAIDEN NAME: Barbara Ann Harting

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Charles Wolpert, R.D., Carpenters Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO (b): 4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John M. Byers, M.D.
EXAMINER'S NAME (Type): John M. Byers, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county): Elkton, Md.
22. DATE SIGNED: 1-30-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 1, 1967
23c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception Cherry Hill
23d. LOCATION (City or Town) (County) (State): Cecil Co. Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR
DATE: FEB 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00570

CERTIFICATE OF DEATH

00573

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
c. LENGTH OF STAY IN 1b: 1 Year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Calvert Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
d. STREET ADDRESS: Reynolds Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Dallas — Last: Blake

4. DATE OF DEATH: Month: Jan — Day: 10 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-27-1884

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Ship Yard

11. BIRTHPLACE (County & State, or foreign country): Maryland Balt. Co

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John D. Blake Sr.

14. MOTHER'S MAIDEN NAME: Florentine Marriott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 230-18-1445

17. INFORMANT — Address: daughter - Julia Rasmussen

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility -Coronary insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 26, 19 66, to 9 Jan, 19 67 that (I) (we) last saw the deceased alive on 9 Jan 67 19___, and that death occurred at 2 AM, from causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10 Jan 67

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22d. ADDRESS: Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-13-1967

23c. NAME OF CEMETERY OR CREMATORY: Zoar Cem.

23d. LOCATION (City or Town) (County) (State): Deltaville Va.

24. FUNERAL DIRECTOR: E. McMullen

ADDRESS: Rising Sun, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00571 00574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 1½ Mon.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL NORTH EAST 07.1
d. STREET ADDRESS: RT. 40
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN — Middle — Last BLOMQUIST
4. DATE OF DEATH: Month 1 — Day 9 — Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-18-09
9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): BROOKLYN, N.Y.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: FRANK MASON
14. MOTHER'S MAIDEN NAME: NO INFO.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: FREDERICK A. BLOMQUIST — Address: NORTH EAST, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion with Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO (b): Hypertensive Cardiovascular Disease — 21 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): —
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f. (City or town) — (County) — (State) —

21. I certify that (I) (this hospital) attended the deceased from June, 1946, to 9 Jan, 1967, that (I) (we) last saw the deceased alive on 9 Jan 1967, and that death occurred at 12:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/9/67
22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER M.D.
22d. ADDRESS: NORTH EAST, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-11-67
23c. NAME OF CEMETERY OR CREMATORY: BAY VIEW CEMETERY
23d. LOCATION (City, town or county) (State): BAY VIEW, MD.
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: Robert Foard 259 E. MAIN ST. ELKTON, MD.
25a. REC'D BY REGISTRAR DATE: JAN 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G385 1/24/67 mh

CERTIFICATE OF DEATH

00572 00575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 6½ hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, North East
d. STREET ADDRESS: Bouchelle Rd. R.D. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Susan — Last: Bouchelle

4. DATE OF DEATH: Month: January — Day: 14 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 1887 Sept. 8, 1889

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Cecil Co. Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Benjamin Rogers

14. MOTHER'S MAIDEN NAME: Mary Susan Cougle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: George R. Bouchelle — Address: North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO (b): Massive myocardial infarction
DUE TO (c): ASCVD
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 420.1
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor / Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this haspital) attended the deceased from Nov., 19 63, to Dec., 19 67 that (I) (we) last saw the deceased alive an Jan. 14 19 67, and that death occurred at 10:35 M, fram causes and an the date stoted above.

22a. SIGNATIIRE: Jay S Barnhart, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/16/67

22c. PHYSICIAN'S NAME (Type): Jay S. Barnhart Jr.

22d. ADDRESS: 4 Mauldin Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/17/67

23c. NAME OF CEMETERY OR CREMATORY: North East Methodist

23d. LOCATION (City or Town) (County) (State): North East Cecil Co. Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22 North East, Md. — Paul R. Church

25a. REC'D BY REGISTRAR DATE: JAN 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00573

CERTIFICATE OF DEATH

00576

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitel, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town): Elkton R.D. #3
d. STREET ADDRESS: Blue Ball Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James Middle: Andrew Last: Burns
4. DATE OF DEATH: Month: January Day: 4, Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 5, 1883
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Burns
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 216-10-1662-A
17. INFORMANT Address: Mrs. Mary Wood, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage, cerebral artery — INTERVAL BETWEEN ONSET AND DEATH: 14 d.
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Basal cell carcinoma, ft auricle
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-21-, 1966, to 1-4-, 1967, that (I) (we) last saw the deceased alive on 1-4-, 1967, and that death occurred at 3:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Tillman D. Johnson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-5-67
22c. PHYSICIAN'S NAME (Type): Tillman D Johnson M.D
22d. ADDRESS: 123 Singerly Ave. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/9/67
23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
23d. LOCATION (City, town or county) (State): Port Deposit, Cecil, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. REC'D BY REGISTRAR DATE: JAN 13 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00574

CERTIFICATE OF DEATH

00577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~XXXXX~~ Elkton
   c. LENGTH OF STAY IN 1b: 10 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
   d. STREET ADDRESS: R.D.# 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Oliver — Middle: — Last: Burns

4. DATE OF DEATH: Month: January — Day: 15 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/12/86

9. AGE (In years last birthday): 80 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STEELWORKER

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): LANDENBERG, Pa.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Benjamin Burns

14. MOTHER'S MAIDEN NAME: WILLIANNA Williamx Milson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 186-16-2024

17. INFORMANT: MAE B. SICKLER — Address: WESTTOWN, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardio Vascular Failure	1 hr
DUE TO (b)	Renal and Hepatic failure	3 days
DUE TO (c)	Diabetic acidosis (coma)	10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension c/ H.C.V.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-22-, 1966, to 1-15-, 1967, that (I) (we) last saw the deceased alive on 1-15-1967, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Luis M. Cuza — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): LUIS M. CUZA, M.D.

22d. ADDRESS: 322 E. CECIL AVE. NORTH EAST, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-18-67

23c. NAME OF CEMETERY OR CREMATORY: NEW LONDON PRESBYTERIAN

23d. LOCATION (City, town or county) (State): NEW LONDON PA.

24. FUNERAL DIRECTOR: Robert J. Tippin — ADDRESS: TIPPIN FUNERAL HOME ELKTON, MD

25a. REC'D BY REGISTRAR — DATE: JAN 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00575 — 00578

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Delaware — b. COUNTY: N.C.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
   d. STREET ADDRESS: S. Chapel St. R. D. #1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: Campbell

4. DATE OF DEATH: Month: 1-19-67 — Day — Year: 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-8-1893

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator

10b. KIND OF BUSINESS OR INDUSTRY: Fibre

11. BIRTHPLACE (County & State, or foreign country): Strickersville, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Campbell

14. MOTHER'S MAIDEN NAME: Sarah Ann Squibb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 221-09-1981

17. INFORMANT: Lettie Campbell — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Coronary occlusion — ?

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEOICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-18, 1967, to 1-19, 1967, that (I) (we) last saw the deceased alive on 1-19 1967, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Williford Eppes — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-22-67

22c. PHYSICIAN'S NAME (Type): Williford Eppes

22d. ADDRESS: Medical Bldg. Main St. Newark, Dela.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1-22-67 — 23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery — 23d. LOCATION (City, town or county) (State): R. D. # 1 Newark, Dela.

24. FUNERAL DIRECTOR: William J Marwick — ADDRESS: Newark, Dela.

25a. REC'D BY REGISTRAR DATE: JAN 26 1967 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00576

CERTIFICATE OF DEATH

00579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Troy; Middle: Harlow; Last: Carter

4. DATE OF DEATH: Month: Jan; Day: 26; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-11-1883

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (County & State, or foreign country): Grant Co. Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sanders Carter

14. MOTHER'S MAIDEN NAME: Millie Sebastin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-36-7520T

17. INFORMANT: Blaine Carter Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: about 5 minutes

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis and coronary
DUE TO (c): artery heart disease. — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Probable obstruction of the large bowel.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1967, to Jan. 26, 1967, that (I) (we) last saw the deceased alive on Jan. 26 1967, and that death occurred at 8 40 a M, from the causes and on the date stated above.

22a. SIGNATURE: S. Ralph Andrews, Jr.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/26/67

22c. PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr.,
22d. ADDRESS: 233 E. Main St., Elkton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-28-1967
23c. NAME OF CEMETERY OR CREMATORY: Freemont Meth. Cem.
23d. LOCATION (City, town or county) (State): Nottingham Pa. R.F.D.

24. FUNERAL DIRECTOR: Vernon E. McMullen
ADDRESS: Rising Sun, Md.
25a. REC'D BY REGISTRAR DATE: JAN 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 information from birth certificate

00577

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00580

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elk Mills
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WANDA — Middle ANN — Last CASTEEL

4. DATE OF DEATH: Month January — Day 31 — Year 19 67

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Dec. 14, 1966	yrs.	1			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Elkton, Md	USA

13. FATHER'S NAME: James E. Casteel

14. MOTHER'S MAIDEN NAME: Jacquelin Dick.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: James E Casteel — Elk Mills, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial pneumonitis SDII — INTERVAL BETWEEN ONSET AND DEATH:
525 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bilaterial catarrhal otitis media

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 1-31-67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/2/67	Elkton Cemetery	Elkton Cecil Md

24. FUNERAL DIRECTOR — ADDRESS: F. Walter duBrey Elkton Md.

25a. REC'D BY REGISTRAR — DATE: FEB 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

L-13943

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00578 00581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
o. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Perryville
c. LENGTH OF STAY IN 1b: 5 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Broad Street

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
o. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Perryville 07.1
d. STREET ADDRESS: Broad Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stella — Middle: May W. — Lost: Cochran

4. DATE OF DEATH: Month: Jan. — Doy: 10, — Year: 19 67

5. SEX: F
6. COLOR OR RACE: Cau.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 3, 1898
9. AGE (In yeors last birthdoy): 68 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (County & Stote, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James A. Webb
14. MOTHER'S MAIDEN NAME: Susan Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service): ---------
16. SOCIAL SECURITY NO.: 229-12-3517
17. INFORMANT: Elmer E. Cochran, Perryville, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Acute Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Congestive Heart failure
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO (c): A.S.C.V.D
4220

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from Jan, 19 62 to Jan 10, 19 67 that (I) (we) last saw the deceased alive on 1-10 19 67, and that death accurred at 9P M, from causes and an the date stated above.

22o. SIGNATURE: John D. Yun — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/11/67
22c. PHYSICIAN'S NAME (Type): JOHN D. YUN
22d. ADDRESS: LAUREL & GRACE AV

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. OATE THEREOF: 1-13-1967
23c. NAME OF CEMETERY OR CREMATORY: Laural Fork Cemetery
23d. LOCATION (City or Town) (County) (Stote): Laural Fork, Va.

24. FUNERAL DIRECTOR ADDRESS: Lee A. Patterson & Son, Perryville, Md.
25o. REC'D BY REGISTRAR DATE: JAN 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00579

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00582

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 4 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 243 E. High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: James — Middle: Everett — Lost: Congo

4. **DATE OF DEATH**: Month: 1 — Day: 5 — Year: 1967

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 4-28-03

9. AGE (In yeors last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grave-digger

10b. KIND OF BUSINESS OR INDUSTRY: Mortuary

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Congo

14. MOTHER'S MAIDEN NAME: Florence Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 221-05-2167

17. **INFORMANT** Address: Mrs. Alverta L. Earl, Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shot-gun Wound of Abdomen — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO (b):
Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying couse lost.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gun accidentally discharged in getting out of car

20c. TIME OF INJURY Month, Day, Year: Hour 4:57 p.m. 1-5 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.): High St., nr. home

20f. (City or town) (County) (State): Elkton Cecil Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John M. Byers, M.D.
EXAMINER'S NAME (Type): John M. Byers, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county):

22. DATE SIGNED: 1-5-67 Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 9 1967
23c. NAME OF CEMETERY OR CREMATORY: Griffith Cem.
23d. LOCATION (City or Town) (County) (State): Cedar Hill, Md.

24. FUNERAL DIRECTOR — ADDRESS: Elmer Bell - 909 Poplar St. Wilm. Del.

25a. REC'D BY REGISTRAR DATE: JAN 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00580

CERTIFICATE OF DEATH

00583

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earleville.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GRACE — Middle V. — Last CRAIG

4. DATE OF DEATH: Month January — Day 24, — Year 1967

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: March, 26, 1888 — 9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home.
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Husfelt.
14. MOTHER'S MAIDEN NAME: Hester Gonce.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.: 217-52-5397
17. INFORMANT: Mrs. Mae Davis, — Address: Cecilton, Md. 21913

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Fracture of left hip intratrochanteric — 14 days
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic obtsructive bronchitis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7 Jan, 1967, to 24 Jan, 1967 that (I) (we) last saw the deceased alive on 24 Jan 67 19, and that death occurred at 4 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 25 Jan 67
22c. PHYSICIAN'S NAME (Type): Wallace Obenshain. M.D.
22d. ADDRESS: Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial.
23b. DATE THEREOF: Jan.26,1967
23c. NAME OF CEMETERY OR CREMATORY: Cecilton Cemetery.
23d. LOCATION (City, town or county) (State): Cecilton, Cecil Co; Md.

24. FUNERAL DIRECTOR: Edward Fellows, — ADDRESS: Millington, Md. 21651
25a. REC'D BY REGISTRAR DATE: JAN 30 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00581

CERTIFICATE OF DEATH

00584

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
   d. STREET ADDRESS: Aiken Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Samuel — Middle: Lee — Last: Craig, Jr.

4. **DATE OF DEATH**: Month: January — Day: 16 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 19, 1896

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Lee Craig, Sr.

14. MOTHER'S MAIDEN NAME: Julia A. Smedley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1942-1946

16. SOCIAL SECURITY NO.: 214-18-1617

17. **INFORMANT** Address: Mrs. Mary W. Craig, Perryville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Minutes
DUE TO
(b): Coronary Insufficiency — 5 Yrs.
DUE TO
(c): Hypertension — 10 Yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 6, 1967 to 1-18, 1967, that (I) (we) last saw the deceased alive on 1-13 1967, and that death occurred at 11 PM M, from causes and on the date stated above.

22a. SIGNATURE: G. H. Richards, Jr. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-20-67

22c. PHYSICIAN'S NAME (Type): G. H. Richards, Jr.

22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/21/1967

23c. NAME OF CEMETERY OR CREMATORY: Principio Cemetery

23d. LOCATION (City or Town) (County) (State): Principio Furnace Cecil Md.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son

ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: JAN 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00582 00585

1. PLACE OF DEATH
a. COUNTY: CECIL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): BLUE BALL ROAD

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: BLUE BALL ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EFFIE Middle MAY Last DAVIS

4. DATE OF DEATH: Month 1 Day 26 Year 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-7-1878
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATCHMAN
10b. KIND OF BUSINESS OR INDUSTRY: PENNA. R.R.
11. BIRTHPLACE (County & State, or foreign country): CECIL CO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN T. WHIRLOW
14. MOTHER'S MAIDEN NAME: RUTH SHEPHERD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 717-07-5684
17. INFORMANT: HARRY H. DAVIS Address: 359 W MAIN ST. ELKTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 2-4 hours
DUE TO (b): Chronic Myocarditis. — 4 yrs.
DUE TO (c): Arteri Sclerosis — 15-18 yrs.
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost. 4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1963, to 1-26-1967, that (I) (we) last saw the deceased alive on 1-25-1967, and that death occurred at 9:50 M, from causes and on the date stated above.

22a. SIGNATURE: Jacob J Greenwald M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/27/67.
22c. PHYSICIAN'S NAME (Type): DR. Jacob. J. Greenwald
22d. ADDRESS: 202 E. Main , St, Elkton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-30-67
23c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY
23d. LOCATION (City or Town) (County) (State): ELKTON CECIL MD.

24. FUNERAL DIRECTOR: Robert Pippin ADDRESS: ELKTON, MD
25a. REC'D BY REGISTRAR DATE: JAN 30 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00583 00586

1. PLACE OF DEATH
a. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ELKTON
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): LEEDS

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ELKTON 07.1
d. STREET ADDRESS: LEEDS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WILLIAM Middle A. Lost DEAVER SR.
4. DATE OF DEATH: Month JANUARY Day 1 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: NOV. 14, 1898
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSURANCE
10b. KIND OF BUSINESS OR INDUSTRY: AGENT
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: JOSEPH DEAVER
14. MOTHER'S MAIDEN NAME: SUSAN —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-01-9509
17. INFORMANT Address: MARGARET W. DEAVER - ELKTON, RD Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, colon & metastases 153.8
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Approx 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug, 1966, to Jan 4, 1967 that (I) (we) last saw the deceased alive on Jan 4, 1967, and that death occurred at 5 P.M., from causes and on the date stated above.

22a. SIGNATURE: Tillman D. Johnson M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1-3-67
22c. PHYSICIAN'S NAME (Type): Tillman D Johnson M.D.
22d. ADDRESS: 163 Singerly Ave, Elkton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN. 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: LEEDS CEMETERY
23d. LOCATION (City or Town) (County) (State): LEEDS, CECIL Md.

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOMES
ADDRESS: ELKTON, Md.
25a. REC'D BY REGISTRAR DATE: JAN 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00584

CERTIFICATE OF DEATH

00587

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN Hospital: 22 days / 1 yr 4 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 13.2
d. STREET ADDRESS: 7915 Ridgley Oak Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLIVER — Middle: LEROY — Last: DESHONG

4. DATE OF DEATH: Month: January — Day: 20 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-9-95

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Freemont Deshong

14. MOTHER'S MAIDEN NAME: Agnes Melfred Oakman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 163-14-0896

17. INFORMANT (Address): VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Aug. 31, 1965, to Jan. 20, 1967 [illegible] and that death occurred at 12:15 pm, from causes and on the date stated above.

22a. SIGNATURE: B. Rothfeld

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-20-67

22c. PHYSICIAN'S NAME (Type): B. ROTHFELD, M.D.

22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: JAN 23 67

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City or Town) (County) (State): Harrisonville Penna

24. FUNERAL DIRECTOR: Eline Funeral Home, ADDRESS: Balto., Md.
FOR Kelso Funeral Home, McConnellsburg, Penna.

25a. REC'D BY REGISTRAR DATE: JAN 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00585 00588

1. PLACE OF DEATH
a. COUNTY: Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warwick
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warwick
d. STREET ADDRESS: 07.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle R. Last FORBES.
4. DATE OF DEATH: Month January Day 12, Year 19 67

5. SEX: Female
6. COLOR OR RACE: White.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: December, 29, 1892
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10b. KIND OF BUSINESS OR INDUSTRY: Home.
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Mabrey.
14. MOTHER'S MAIDEN NAME: Susan Scuse.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 216-48-5686
17. INFORMANT: Stewart W. Forbes, Address: New Castle, Del. 103 Del. Dr. Collins Park,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease.
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 6 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1966, to ~~12~~ Jan, 1967, that (I) (we) last saw the deceased alive on 12 Jan 19 67, and that death occurred at 7:00 ~~AM~~ PM from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 13 Jan 67
22c. PHYSICIAN'S NAME (Type): Wallace Obenshain. M.D.
22d. ADDRESS: Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Millington Cemetery.
23d. LOCATION (City, town or county) (State): Millington, Kent Co; Md.

24. FUNERAL DIRECTOR: Edward Fellows, ADDRESS: Millington, Md. 21651
25a. REC'D BY REGISTRAR DATE: JAN 17 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00586

CERTIFICATE OF DEATH

00589

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 20 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): Union Hospital Of Cecil County

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 278 Hollingsworth Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: F. — Last: Gillen

4. DATE OF DEATH: Month: January — Day: 7 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/31/15

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant Wa
10b. KIND OF BUSINESS OR INDUSTRY: Perrypoint Hosp.

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Seaton Gillen

14. MOTHER'S MAIDEN NAME: Flora Sheppard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 227-12-4291

17. INFORMANT: Mrs. Pauline Gillen — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary withMyocardial Infarct- — INTERVAL BETWEEN ONSET AND DEATH: 1-Hours
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
(b): ion.
DUE TO
(c): Chronic Myocarditis — 1-Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/10/ , 19 65 to 1/7/ , 1967, that (I) (~~we~~) last saw the deceased alive an 1/7/ 1967, and that death accurred at 6:10 A.M, from causes and an the date stated abave.

22a. SIGNATURE: James L. Johnson
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan. 9, 1967

22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.
22d. ADDRESS: 245 East High St., Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/10/67
23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memorial
23d. LOCATION (City or Town) (County) (State): Park, Elkton, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: JAN 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00587 00590

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Walnut Lane

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 303 Elkton Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ann; Middle: Racine; Last: Gillespie

4. DATE OF DEATH: Month: January; Day: 17; Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 3, 1902

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse (R.N.)

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles David Racine

14. MOTHER'S MAIDEN NAME: Harriett R. Holden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 219-12-7786

17. INFORMANT: Irvin P. Racine, Wendenhall, Pa.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 25 min
420.1
DUE TO
(b): Arteriosclerotic Heart Disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan., 1961, to 1-17-1967, that (I) (we) last saw the deceased alive on 1-17-1961, and that death occurred at 2:23 AM, from the causes and on the date stated above.

22a. SIGNATURE: Tillman D Johnson
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-17-67

22c. PHYSICIAN'S NAME (Type): Tillman D Johnson M.D.

22d. ADDRESS: 123 Singerly Ave, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/20/67

23c. NAME OF CEMETERY OR CREMATORY: North East Methodist Cemetery

23d. LOCATION (City, town or county) (State): North East, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: JAN 30 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00588

CERTIFICATE OF DEATH

00591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   c. LENGTH OF STAY IN 1b: 1 WEEK
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): UNION HOSPITAL

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: MD
   b. COUNTY: CECIL
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): ELKTON 07.1
   d. STREET ADDRESS: 151 E. MAIN
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First PEYTON — Middle R. — Lost HARRISON

4. **DATE OF DEATH**: Month 1 — Doy 9 — Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-6-1878

9. AGE (In yeors lost birthdoy): 88 yrs.

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: RETAIL SALES

11. BIRTHPLACE (County & State, or foreign country): BALTIMORE CO. MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: DR. HENRY T. HARRISON

14. MOTHER'S MAIDEN NAME: MARION JENIFER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 212-30-2672

17. INFORMANT: ELSIE C. HARRISON — Address 151 E. MAIN, ST. ELKTON, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Acute Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 24hrs.
DUE TO
(b): Acute peritonitis — 24hrs.
DUE TO
(c): Large bowel perforation — 11
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
5788

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): AUS possible large bowel tumor?

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Dec, 1966, to 1/9, 1967, that (I) (we) last saw the deceased alive on 1/9 1966, and that death occurred at 9:40 M, from causes and on the date stated above.

22o. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/10/67

22c. PHYSICIAN'S NAME (Type): PETER STAVRAKIS M.D.

22d. ADDRESS: ELKTON MD.

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-12-67

23c. NAME OF CEMETERY OR CREMATORY: PROSPECT HILL

23d. LOCATION (City or Town) (County) (State): TOWSON, MD.

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS 254 E. MAIN ELKTON, MD — Robert Foard

25o. REC'D BY REGISTRAR DATE: JAN 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00589 00592

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton 07.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	MAY	B.	HINES		January	1,	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		January, 10, 1893	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	London, England	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Plant.	Mary Grogan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No.	None.	Frank Hines,	Cecilton, Md. 21913

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the left kidney — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
180X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gram-negative septicemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 12 Dec, 1966 to 1 Jan 66, 19___, that (I) (we) last saw the deceased alive on 1 Jan 66 19___, and that death occurred at 12:00 noon M, from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/3/67
22c. PHYSICIAN'S NAME (Type): Wallace Obenshain. M.D.
22d. ADDRESS: Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
Burial	Jan.4,1967	Galena Cemetery.	Galena, Kent Co;	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Edward Fellows,	Millington, Md.	JAN 5 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00590 00593

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELK FORREST 07.1
d. STREET ADDRESS: #7 ELK FORREST Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MOSELLE Middle B. Last HIRST
4. DATE OF DEATH: Month JANUARY Day 11 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 21, 1913
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: STORE
11. BIRTHPLACE (County & State, or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE BUFFALOE
14. MOTHER'S MAIDEN NAME: GOLDIE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: WALTER R. HIRST Address: RD #2 ELKTON MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 490X Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia, severe, type undetermined.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-6-, 1967, to 1-11-, 1967, that (I) (we) last saw the deceased alive on 1-11-, 1967, and that death occurred at 3 25 PM, from the causes and on the date stated above.

22a. SIGNATURE: Tillman D. Johnsen M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-13-67
22c. PHYSICIAN'S NAME (Type): Tillman D. Johnsen M.D.
22d. ADDRESS: 123 Sinsert Ave., Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/14/67
23c. NAME OF CEMETERY OR CREMATORY: GILPIN MANOR MEM. PK
23d. LOCATION (City, town or county) (State): ELKTON, Md.

24. FUNERAL DIRECTOR: W.H. PIPPIN FUNERAL HOME
ADDRESS: Donald Dee ELKTON Md.
25a. REC'D BY REGISTRAR DATE: JAN 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00591 — 00594

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 mos 19 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 21218
d. STREET ADDRESS: 2302 Garrett Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle PETER — Last HUBER

4. DATE OF DEATH: Month January — Day 23 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-6-87

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher, retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael L. Huber (D)

14. MOTHER'S MAIDEN NAME: Catherine Baker (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 215-07-1861

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1½-2 days
DUE TO
(b): Arteriosclerotic heart disease — ---
DUE TO
(c): Arteriosclerosis, generalized — years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from Oct. 6, 19 66, to Jan. 23, 19 67 that I (we) last saw the deceased alive on and that death occurred at 7:10 am, from causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-23-67

22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, MD.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: Jan.26.1967

23c. NAME OF CEMETERY OR CREMATORY: Most Holy Redeemer Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore Md.

24. FUNERAL DIRECTOR — ADDRESS: Maryland
H. Sanders & Son, North Ave & Broadway, Balt

25a. REC'D BY REGISTRAR — DATE: JAN 25 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00592

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00595

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: 14 Rolling Mill Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ROBERT — Middle CARL — Last ISAACS

4. **DATE OF DEATH**: Month January — Day 30 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-15-1932

9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABOR

10b. KIND OF BUSINESS OR INDUSTRY: BASKET FACTORY

11. BIRTHPLACE (State or foreign country): NORTH EAST, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: LEWIS ISAACS, SR.

14. MOTHER'S MAIDEN NAME: EVA LOCKARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): KOREA

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: LEWIS ISAACS, JR. NORTH EAST, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Artery Embolism
DUE TO
(b): Popliteal Vein Thrombosis
DUE TO
(c): Perineal Abscess.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
6921
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Charles S. Petty
Address (Street, city, town, or county)

22. DATE SIGNED: 1/30/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-2-67
23c. NAME OF CEMETERY OR CREMATORY: NORTH EAST METH.
23d. LOCATION (City or Town) (County) (State): NORTH EAST CECIL MD.

24. FUNERAL DIRECTOR: GRANT FUNERAL HOME — ADDRESS: NORTH EAST, MD.

25a. REC'D BY REGISTRAR DATE: FEB 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00593

CERTIFICATE OF DEATH

00596

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 days / 20 yrs 9 mos

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catasauqua 75.3
d. STREET ADDRESS: 200 Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

3. NAME OF DECEASED (Type or print): First: JOSEPH — Middle: A. — Last: KARO

4. DATE OF DEATH: Month: January — Day: 18 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 6-11-12

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Textile worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Northhampton, Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Karo

14. MOTHER'S MAIDEN NAME: Rose Orban

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 194-07-7637

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lob ar Pneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 2-3 Wks
DUE TO
(b): Carcinoma of Naso-Pharynx with Extension into Base of Skull — 6-12 Mos.
DUE TO
(c):

146X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~XX~~ (this hospital) attended the deceased from Jan. 23, 19 46, to Jan. 18, 1967, ~~that I (we) last~~ ~~saw the deceased alive on~~ ~~and that death occurred at~~ 3:07 am, from causes and on the date stated above.

22a. SIGNATURE: Alfred G. Gillis M.D. — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☒

22b. DATE SIGNED: 1-18-67

22c. PHYSICIAN'S NAME (Type): Alfred G. Gillis, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: Jan. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Our Lady of Hungary Cem

23d. LOCATION (City or Town) (County) (State): Northampton Penna

24. FUNERAL DIRECTOR — ADDRESS: Swallow Funeral Home, Northampton, Pa.

25a. REC'D BY REGISTRAR — DATE: JAN 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00594 — 00597

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4 mos 19 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1010 P Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47.3

27

3. NAME OF DECEASED (Type or print): First JAMES — Middle NMI — Last LANG

4. DATE OF DEATH: Month January — Day 3 — Year 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-7-00

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Lancaster Co., S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ned Lang (D)

14. MOTHER'S MAIDEN NAME: Fannie Robinson (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 577-12-3722

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 10-19 days
DUE TO (b): Bronchogenic carcinoma of left lung — 9-12 mos.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Aug. 17, 1966, to Jan. 3, 1967, that ~~I (we) last~~ ~~saw the deceased alive on~~ and that death occurred at 12:50 pm, from causes and on the date stated above.

22a. SIGNATURE: J. C Blancaflor — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-4-67

22c. PHYSICIAN'S NAME (Type): JOEL BLANCAFLOR, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 1-9-67

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Ft. Myer, Va.

24. FUNERAL DIRECTOR — ADDRESS: Frazier Funeral Home, Washington, DC

25a. REC'D BY REGISTRAR — DATE: JAN 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00595

CERTIFICATE OF DEATH

00598

1. **PLACE OF DEATH**
   a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town): CALVERT
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CALVERT NURSING HOME

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Pa
   b. COUNTY: Chester
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Offord
   d. STREET ADDRESS: 29 N. 4th
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First FRANCES — Middle R — Last LEE

4. **DATE OF DEATH**: Month Jan. — Day 13 — Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 30. 1883

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reg. Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (County & State, or foreign country): Nottingham P.O. Pa

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Leonard W. Lee

14. MOTHER'S MAIDEN NAME: Edeya Fallenger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 198-30-9045

17. **INFORMANT** Address: Elizabeth Yerkes. Rising Sun. R.D. 2 Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arteria Sclerotic Heart Di — 3 days
DUE TO (c): — 5 years
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
I 20.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Home, form, factary, street, affice bldg., etc.)

20f. (City ar town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec, 1966, ta Jan, 1967 that (I) (we) last saw the deceased alive an Jan 12 1967, and that death accurred at 6.05 PM, from couses and an the date stated above.

22a. SIGNATURE: Ernest W. Lester M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan 14, 1967

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan 17 1967

23c. NAME OF CEMETERY OR CREMATORY: Offord Cem.

23d. LOCATION (City or Town) (County) (State): Offord, Chester Co Pa

24. FUNERAL DIRECTOR: RALPH M. REED, ADDRESS: Ralph M Reed - RISING SUN, MD.

25a. REC'D BY REGISTRAR DATE: JAN 17 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00596 00599

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE CITY
c. LENGTH OF STAY IN 1b: 49 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NONE

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE CITY 07
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SOPHIA — Middle — Last LYSAIC
4. DATE OF DEATH: Month 1 — Day 2 — Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-14-1895
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): UKRAINE
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: NO INFO
14. MOTHER'S MAIDEN NAME: NO INFO
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: PAUL LYSAK — Address: CHESAPEAKE CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1966, to Jan 2, 1967, that (I) (we) last saw the deceased alive on Jan 2 1967, and that death occurred at 3P M, from the causes and on the date stated above.

22a. SIGNATURE: Henry V. Davis M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/3/67
22c. PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD
22d. ADDRESS: CHESAPEAKE CITY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-7-67
23c. NAME OF CEMETERY OR CREMATORY: ST. ROSE OF LIMA
23d. LOCATION (City, town or county) (State): CHESAPEAKE CITY, MD.
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: Robert Road, ELKTON, MD
25a. REC'D BY REGISTRAR — DATE: JAN 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00597

CERTIFICATE OF DEATH

00600

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN: 19 days; 8 yrs 2 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2938 E. Fayette Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM; Middle: B.; Last: MARSHALL

4. DATE OF DEATH: Month: January; Day: 19; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-26-~~95~~ '95

9. AGE (In years last birthday): ~~90~~ 71 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ship chandler

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Marshall

14. MOTHER'S MAIDEN NAME: Frances Parley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 215-12-5939A

17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10-14 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Urinary tract infection (acute pyelonephritis, pyonephrosis, cystitis) — --
(c): Bladder stones — --
604X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from Nov. 3, 1958, to Jan. 19, 1967 ~~xxxxxxxxxx~~, that (I) (we) last saw ~~the deceased alive on xxxxxxxxxxxxxxxx~~ and that death occurred at 2:45 a.m., from causes and on the date stated above.

22a. SIGNATURE: E. E. Folk III
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): E. E. FOLK, M.D.
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): ~~Removal~~ Burial 1/21/'67
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: Moran Funeral Home, 3000 East Balto. St.,
ADDRESS: Balto., Md.

25a. REC'D BY REGISTRAR DATE: JAN 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00598

CERTIFICATE OF DEATH

00601

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 mos. 24 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Keedysville
d. STREET ADDRESS: RD # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS; Middle; Last McAFEE

4. DATE OF DEATH: Month January; Day 12; Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-3-96

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Foxville, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathaniel McAfee (D)

14. MOTHER'S MAIDEN NAME: Effie Holmes (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 220-09-9268

17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Squamous cell carcinoma, nasopharynx with
DUE TO: invasion of posterior fossa
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 146X
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 4 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~XX~~(this hospitol) attended the deceased from August 17, 1966, to Jan. 12, 19 67, ~~last (x) days~~ saw the deceased alive on ~~xxxxxxxxxxxxxxxxxxxx~~ and that death occurred at 10:30 a.m. from causes and on the date stated above.

22a. SIGNATURE: J. E. Blancaflor Jr.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-12-67

22c. PHYSICIAN'S NAME (Type): JOEL BLANCAFLOR, M.D.

22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 1- 14- 67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR ADDRESS: John H. Bast, Jr. Bast Funeral Home, Boonsboro, Md.

25a. REC'D BY REGISTRAR DATE: JAN 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00593 — 00602

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): North East
   c. LENGTH OF STAY IN 1b: 20 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): No. 8 East Cecil Ave.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East — 07.1
   d. STREET ADDRESS: No. 8 East Cecil Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Lewis — Last: McCall

4. DATE OF DEATH: Month: January — Day: 9 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 15, 1906

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy Equipment Oper.

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): Cecil County, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Daisy McCall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-14-9461

17. INFORMANT: Mrs. Alice E. McCall — Address: No. 8 East Cecil Ave North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 5 min

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — 4 yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): Cardiac cirrhosis with Ascites

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) —

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) — (County) — (State) —

21. I certify that (I) (this hospital) attended the deceased from 6/17, 1966 to 9 Jan, 1967, that (I) (we) last saw the deceased alive on 9 Jan 1967, and that death occurred at 5:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/9/67

22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER

22d. ADDRESS: NORTH EAST, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/13/67

23c. NAME OF CEMETERY OR CREMATORY: North East Methodist Cem.

23d. LOCATION (City, town or county) (State): North East Maryland

24. FUNERAL DIRECTOR: Grant Funeral Home — Paul R. Crouch

ADDRESS: Box 22 North East, Md.

25a. REC'D BY REGISTRAR DATE: JAN 12 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00600 — 00603

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 4 wks.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D. # 3
   d. STREET ADDRESS: Pleasant Hill
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Velma — Middle: G. — Last: McConnell

4. **DATE OF DEATH**: Month: January — Day: 21, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 29, 1906

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: R.R. Corp.

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Russell Gregg

14. MOTHER'S MAIDEN NAME: Elizabeth Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-01-1138

17. INFORMANT: Charles J. McConnell — Address: R.D. # 3, Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Bowel with Metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

153.9

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/15, 19 67, to 1/21, 19 67, that (I) (we) last saw the deceased alive on 1/20 19 67, and that death occurred at 2:00 M, from the causes and on the date stated above.

22a. SIGNATURE: John A. Fischer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): John A. Fischer

22d. ADDRESS: ELKTON, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/25/67

23c. NAME OF CEMETERY OR CREMATORY: Little Britain Presbyterian Cemetery, Little Britain

23d. LOCATION (City, town or county) (State): Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: JAN 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A1S (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00601 — 00604

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 83 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit 07.1
d. STREET ADDRESS: 104 North Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLYDE — Middle G. — Last McGLOTHLIN

4. DATE OF DEATH: Month January — Day 17 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-12-20

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Buck County, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. McGlothlin (D)

14. MOTHER'S MAIDEN NAME: Martha D. Jackson (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes — WW II

16. SOCIAL SECURITY NO.: 177-10-9725

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pleural effusion left Bronchopneumonia, bilateral w/massive — INTERVAL BETWEEN ONSET AND DEATH: 10days-2 weeks
DUE TO
(b): Carcinoma of right lung w/widespread metastasis 1-1½ yrs
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Oct. 26, 1966, to Jan. 17, 1967 ~~that I (saw) last saw~~ the deceased alive on ~~xxxxxxxxxxxxxx~~ 19~~xxxx~~ and that death occurred at 8:30 am, from causes and on the date stated above.

22a. SIGNATURE: A. G. Gillis
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1-17-67
22c. PHYSICIAN'S NAME (Type): A. G. GILLIS, M.D.
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 1/20/1967
23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
23d. LOCATION (City or Town) (County) (State): Port Deposit Cecil Md

24. FUNERAL DIRECTOR — ADDRESS: Patterson Funeral Home, Perryville, Md.

25a. REC'D BY REGISTRAR DATE: JAN 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00602

CERTIFICATE OF DEATH

00605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural, North East
   c. LENGTH OF STAY IN 1b: 10 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.D. 2

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Penna. — b. COUNTY: Philadelphia
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia — 75.3
   d. STREET ADDRESS: 4735 Hazel Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First EDWARD — Middle B. — Last McLAUGHLIN

4. **DATE OF DEATH**: Month Jan. — Dey 1 — Year 19 ~~66~~ 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 25, 1901

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banker

10b. KIND OF BUSINESS OR INDUSTRY: Banking

11. BIRTHPLACE (County & State, or foreign country): Delaware Co. Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward B. McLaughlin

14. MOTHER'S MAIDEN NAME: Anna Burns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 159-07-6873

17. INFORMANT: Margaret D. Lipsey — Address: R.D. 2 North East, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left ventricular hypertrophy and failure — INTERVAL BETWEEN ONSET AND DEATH: 10 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Atherosclerosis — 14 years

DUE TO (c): Hypertensive Cardio-Vascular Disease — 16 years

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/23, 1966 to 1/1, 1967 that (I) (we) last saw the deceased alive on 28 Dec 1966, and that death occured at 1:15 P.M. from the causes and on the date stated above.

22e. SIGNATURE: Klaus H. Huebner M.D. — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/1/67

22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER

22d. ADDRESS: NORTH EAST, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/6/67

23c. NAME OF CEMETERY OR CREMATORY: Immaculate Heart Cem.

23d. LOCATION (City, town or county) (State): Linwood, Del Co. Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: Grant Funeral Home Paul R. Crouch — ADDRESS: Box 22 North East, Md.

25a. REC'D BY REGISTRAR DATE: JAN 4 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00603 (M) 00606

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 241 E. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: N. — Middle: Edward — Last: Miller

4. DATE OF DEATH: Month: January — Day: 8 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 24, 1901

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Spitz Lab.

11. BIRTHPLACE (County & State, or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Norman P. Miller

14. MOTHER'S MAIDEN NAME: Ella P. Salisbury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-01-2150

17. INFORMANT — Address: Mrs. Margaret M. Miller, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	6 Hours
443X — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Cerebral Atherosclerosis	1 yr
DUE TO (c)	Hypertensive Cardiovascular Disease	1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): —

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19 —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town) — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from Dec, 1965 to 8 Jan, 1967, that (I) (we) last saw the deceased alive on 8 Jan 1967, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/8/67

22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER M.D.

22d. ADDRESS: NORTH EAST, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/12/67

23c. NAME OF CEMETERY OR CREMATORY: Rosebank Cemetery

23d. LOCATION (City, town or county) (State): Calvert, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 13 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00604

CERTIFICATE OF DEATH

00607

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 13 days / 3 yrs 3 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: RD # 2, Box ~~52~~ 48
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
LUTHER	E.	QUILLEN	January	17	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	DIVORCED ☒	12-3-28	38 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
~~None~~ Laborer	Air Craft Plant	Rugby, Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Luther Quillen (D)	Eula Walton (L)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	1-9-51 to 10-8-52	214-26-8986 VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Aspiration Pneumonia, Recurrent	4-7 Days
DUE TO (b)	MULTIPLE SCLEROSIS	10 Years
DUE TO (c)		

345X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that ~~XIX~~ (this hospital) attended the deceased from May 27, 1963, to Jan. 17, 1967, ~~that (I) (we) last saw the deceased on the~~ xxxxxxxxxxxxxxxx, and that death occurred at 11:25 ~~a~~ p.m., from causes and on the date stated above.

22a. SIGNATURE — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 1-18-67

22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D. — 22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	21 Jan. 67	Mt Zion Cemetery	Bel Air, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: JAN 20 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00605 — 00608

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORTHEAST
d. STREET ADDRESS: 211 S. MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ELIZABETH — Last: REYNOLDS

4. DATE OF DEATH: Month: 1 — Day: 1 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 28 1894

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BENJAMIN BURNS

14. MOTHER'S MAIDEN NAME: WILLIE ANN MILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-16-9372 B

17. INFORMANT: MRS ALBERT SWANSON — Address: 22 KENT ROAD, ELKWOOD ESTATES, ELKTON MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Inst
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): FELL AT HER DOUGHTERS HOUSE

20c. TIME OF INJURY Month, Day, Year: Hour a.m. 5 p.m. — 1/1 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town) ELKTON (County) Cecil (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Henry V. Davis M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): HENRY V. DAVIS MD — Address (Street, city, town, or county): ELKTON Cecil Co MD

22. DATE SIGNED: 1/1/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/5/67
23c. NAME OF CEMETERY OR CREMATORY: Principio Meth. Cem
23d. LOCATION (City, town or county) (State): Principio-Cunice, Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22 — Paul R. Crouch North East, Md.

25a. REC'D BY REGISTRAR DATE: JAN 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00606 — 00609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS: 217 W. Main Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mary — Middle: A. — Last: Rinehart

4. **DATE OF DEATH**: Month: January — Day: 16, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10, 1890

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U,S,A,

13. FATHER'S NAME: George Potts

14. MOTHER'S MAIDEN NAME: Julia Corriden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 168-09-1960D

17. **INFORMANT**: Raymond P. Rhinehart, Charlottesville Address Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Hypertensive Arteriosclerotic heart disease — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Metastatic Carcinoma, Left Groin

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/9, 19 67 to 1/16, 19 67, that (I) (we) last saw the deceased alive on 1/15 19 67, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: John A Fischer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/23/67

22c. PHYSICIAN'S NAME (Type): John A. Fischer

22d. ADDRESS: ELKTON, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/18/67

23c. NAME OF CEMETERY OR CREMATORY: Boulden's Chapel Cemetery, Elkton, Cecil, Md.

23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: JAN 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00607 00610

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b: 1 mo. 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 15 S. Main Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Port Deposit
d. STREET ADDRESS: Apt. #3, 15 S. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVERETT — ~~WALLACE~~ WELLES — ~~RENSGROVE~~ RUSGROVE — Jr.

4. DATE OF DEATH: Month January — Doy 20, — Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-29-66
9. AGE (In yeors lost birthday) yrs. 1- [illegible] 23 — IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Everett W. Rusgrove Sr.
14. MOTHER'S MAIDEN NAME: Nancy Balog

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Everett W. Rusgrove Sr. Address: 15 S. Main St. Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial pneumonitis (SDII) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
(b)
DUE TO
(c)
525X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURREO. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Ooy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
OEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
Address (Street, city, town, or county): January 20, 1967
22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/22/67
23c. NAME OF CEMETERY OR CREMATORY: St. Mary Anne's
23d. LOCATION (City or Town) (County) (State): North East Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: North East, Md. — Paul R. Crouch
25a. RECD BY REGISTRAR DATE: JAN 23 1967
25b. REGISTRAR'S SIGNATURE: [signature]

VR A15ME (5) 6M 1/67

6-46

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00608 — 00611

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b: 7 hrs 31 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Station Hospital, USNTC

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Manor Heights 07.1
d. STREET ADDRESS: Apt 233-A Laffey Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (Not named) — Middle — Last SAVAGE

4. DATE OF DEATH: Month January — Day 29 — Year 1967

5. SEX: Male

6. COLOR OR RACE: Negroid

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 29 January 1967

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours 7 — Min. 31

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (County & State, or foreign country): Cecil County, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HERMAN (n) SAVAGE

14. MOTHER'S MAIDEN NAME: ETTIE MAY McCLARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ----
(If yes give war or dates of service): -----

16. SOCIAL SECURITY NO.: ----

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY ATELECTASIS — INTERVAL BETWEEN ONSET AND DEATH
761.5
DUE TO (b): PREMATURITY — HOURS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): PREMATURE SEPARATION OF PLACENTA

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from 29 January, 1967, to 29 Jan., 1967, that (I) (we) last saw the deceased alive on 29 January 1967, and that death occurred at 9:30 PM, from causes and on the date stated above.

22a. SIGNATURE: Sol Rockenmacher. — M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): SOL ROCKENMACHER LT MC USNR

22d. ADDRESS: USNTC, Station Hospital, Bainbridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 31 January 1967

23c. NAME OF CEMETERY OR CREMATORY: Aberdeen Proving Ground Cemetery

23d. LOCATION (City or Town) (County) (State): Aberdeen, Harford, Md.

24. FUNERAL DIRECTOR: LEE A. PATTERSON & SON

ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE FEB 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

7-231913

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G365 1/31/67 mh

00603

CERTIFICATE OF DEATH

00612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest tawn): Perryville
c. LENGTH OF STAY IN 1b: 4 Mo 19 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): V A Hospital, Perry Point, Md.

2. USUAL RESIDENCE (Where deceosed lived, if institutian: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Havre de Grace, M
d. STREET ADDRESS: Meadowvale Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type ar print): First CYRUS — Middle C — Lost SHARP

4. DATE OF DEATH: Month January — Day 17 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-17-90

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Haurs — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dentist

10b. KIND OF BUSINESS OR INDUSTRY: Dental

11. BIRTHPLACE (Caunty & State, ar foreign cauntry): Ontario, Canada

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SHARP (Deceased)

14. MOTHER'S MAIDEN NAME: Augusta BROWN (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknawn) Yes (If yes give wor or dates of service) WW I

16. SOCIAL SECURITY NO.: 217-54-7564

17. INFORMANT Address: Hospital records, VAH., Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema
DUE TO (b): Arterioscalertic heart disease with myocardial fibrosis
DUE TO (c): Arteriosclerosis generalized
Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.
4200
INTERVAL BETWEEN ONSET AND DEATH: (b) years; (c) Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.)

20c. TIME OF INJURY Manth, Day, Yeor Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 8-29, 1966, to 1-17-, 1967, ~~that I (have) (have not) viewed the body~~ and that death occurred at 4:00PM, from causes and on the date stated above.

22a. SIGNATURE

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-18-67

22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.

22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE THEREOF 1/20/67

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill

23d. LOCATION (City or Town) (County) (State): Havre de Grace Md

24. FUNERAL DIRECTOR ADDRESS: PENNINGTON & SON - Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE JAN 20 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00610

CERTIFICATE OF DEATH

00613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 13 days / 5 yr 3 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryman 12.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIS — Middle F. — Last SLATTERY

4. DATE OF DEATH: Month January — Day 3 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-10-93

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Gardner~~ Seaman

10b. KIND OF BUSINESS OR INDUSTRY: Merchant Marine

11. BIRTHPLACE (County & State, or foreign country): Perryman, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William J. Slattery (D)

14. MOTHER'S MAIDEN NAME: Ella Thompson (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 218-03-3029

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days
DUE TO
(b): left ventricle Acute myocardial infarction w/mural thrombus — 10-18 days
DUE TO
(c): Arteriosclerotic heart disease — 4-5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from July 18, 1961, to Jan. 3, 1967 that ~~I (this physician) saw the deceased~~ and that death occurred at 4:00 a.m. M, from causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-3-67

22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6 Jan. 67

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Havre de Grace, Maryland

24. FUNERAL DIRECTOR — ADDRESS: John G. Torrey — Tarring Funeral Home, Aberdeen, Maryland

25a. REC'D BY REGISTRAR — DATE: JAN 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00611

CERTIFICATE OF DEATH

00614

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 12.2
d. STREET ADDRESS: 321 Strawberry Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ERNEST — Middle: W. — Last: STOKES

4. DATE OF DEATH: Month: January — Day: 23 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 3-4-95

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer + Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Lumber Co.

11. BIRTHPLACE (County & State, or foreign country): Rollingsville, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Augustus Stokes (D)

14. MOTHER'S MAIDEN NAME: Bertha (?) (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 221-09-8447

17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-Pneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 4-7 days
420.0
DUE TO
(b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arteriosclerosis, Generalized — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Jan. 18, 1967, to Jan. 23, 19 67 ~~saw the deceased alive on~~ and that death occurred at 12:05 am from causes and an the date stated above.

22a. SIGNATURE: Joaquin R. Garcia M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Joaquin R. Garcia, M.D.
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
23b. DATE THEREOF: 1-26-1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore Md.

24. FUNERAL DIRECTOR: Otelia L. Bullock
ADDRESS: Bullock's Mortuary, Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: JAN 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00612 — 00615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 4 hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Rising Sun
   d. STREET ADDRESS: R.D. 1
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First AXEL — Middle IVAR — Last STROMFORS

4. **DATE OF DEATH**: Month January — Day 6 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 23, 1902

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (County & State, or foreign country): Finland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sal Stromfors

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 086-01-9773

17. INFORMANT: Mrs. Hilja E. Stromfors — Address: R.D. 1 Rising Sun, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio Vascular Failure	10 min
DUE TO (b)	Liver & Renal failure	2 wks
DUE TO (c)	Ca of Stomach c/ Multiple Metastasis	1 year

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension of H.C.V.D. & Gen. arth sclerosis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-19-, 1960 to 1-6-, 1967, that (I) (we) last saw the deceased alive on 1-6-1967, and that death occured at 1:03 PM, from the causes and on the date stated above.

22a. SIGNATURE: Luis M. Cuza — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 1-7-67

22c. PHYSICIAN'S NAME (Type): Luis M. Cuza

22d. ADDRESS: North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/8/67

23c. NAME OF CEMETERY OR CREMATORY: North East Meth. Cem.

23d. LOCATION (City, town or county) (State): North East, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Grant Funeral Home, Paul R. Crouch, Box 22, North East, Md.

25a. REC'D BY REGISTRAR DATE: JAN 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00613

CERTIFICATE OF DEATH

00616

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON
c. LENGTH OF STAY IN 1b 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East
d. STREET ADDRESS R.D. 2.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Florence Middle: May Last: Ulary
4. DATE OF DEATH Month: January Day: 28 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 10, 1875
9. AGE (In years last birthday) 91 yrs.
IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Genhart
14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 220-46-4934
17. INFORMANT George H. Ulary Address R.D. 2 Box 145 North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left cerebral thrombosis with rt. Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b) Cerebral Atherosclerosis — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive Cardiovascular Disease — 5 yrs
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2 May, 1962 to 28 Jan, 1967, that (I) (we) last saw the deceased alive on 1/27 1967, and that death occurred at 7A.M, from causes and on the date stated above.

22a. SIGNATURE Klaus H. Huebner M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 1/28/67
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER
22d. ADDRESS NORTH EAST, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 1/31/67
23c. NAME OF CEMETERY OR CREMATORY North East Methodist
23d. LOCATION (City or Town) (County) (State) North East Cecil Md.

24. FUNERAL DIRECTOR Grant Funeral Home ADDRESS Paul R. Grant Box 22 North East, Md.
25a. REC'D BY REGISTRAR DATE JAN 31 1967
25b. REGISTRAR'S SIGNATURE Josephine Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00614

CERTIFICATE OF DEATH

00617

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): VA Hospital, Perry Point, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 613 North Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MICHAEL — Middle G — Last VONG

4. DATE OF DEATH: Month January — Day 23 — Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-15-96
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Laborer~~ Grocer
10b. KIND OF BUSINESS OR INDUSTRY: Delicatessen
11. BIRTHPLACE (County & State, or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE VONG (Deceased)
14. MOTHER'S MAIDEN NAME: CONTANTO (Unknown) (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 222-01-8096
17. INFORMANT Address: Va Hospital records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rupture of dissecting aneurysm of ascending — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): aorta
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Jan 1, 19 67, to Jan. 23, 19 67 ~~that I have last~~ and that death occurred at 6:20 PM, from causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 1-24-67
22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 1/27/67
23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
23d. LOCATION (City or Town) (County) (State): Elkton Cecil Md.

24. FUNERAL DIRECTOR: W. Wallis du Bois
ADDRESS: DUBOSE FUNERAL HOME, Elkton, Maryland
25a. REC'D BY REGISTRAR DATE: JAN 30 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00615

CERTIFICATE OF DEATH

00618

1. PLACE OF DEATH
   a. COUNTY: Cecil
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b: 16 Yrs-2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): VA Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY
   c. CITY OR TOWN (If outside carporote limits, write RURAL and give neorest town): Baltimore
   d. STREET ADDRESS: 506 S Montford Ave.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: A.; Lost: WATROBA

4. DATE OF DEATH: Month: January; Doy: 8,; Year: 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12 28 26

9. AGE (In yeors lost birthday) 40 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & Stote, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph J. Watroba

14. MOTHER'S MAIDEN NAME: Mary J. Posko

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dotes of service): WWII

16. SOCIAL SECURITY NO.: 219-10-99-80

17. INFORMANT: Records — Address: VA Hospital - Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Undetermined (died in sleep) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Pulmonary Embolism (?)
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 1 5 51, 19 a.m. to 1 8 67, 19 ~~That (I) (we) last saw the deceased alive on~~, and that death occurred at 6:30 M, from causes and on the date stated above.

22a. SIGNATURE: G. A. Reynolds M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-8-67

22c. PHYSICIAN'S NAME (Type): G. A. REYNOLDS, M.D.

22d. ADDRESS: VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 1/11/67

23c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Charles Sadowski ADDRESS: 1808 Baltimore, Md. Eastern Ave

25a. REC'D BY REGISTRAR DATE: JAN 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00616 00619

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Marylan d — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: R.D. # 5
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: Marie — Last: Whitelock
4. DATE OF DEATH: Month: January — Day: 15, — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: May 31, 1872
9. AGE (In years last birthday): 94 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick C. Whitelock
14. MOTHER'S MAIDEN NAME: Annie Bernard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Davis, Elkton, Md. R.D.5 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 d.
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis, generallized, severe — many years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-12-, 1967, to 1-12-, 1967, that (I) (we) last saw the deceased alive on 1-15-1967, and that death occurred at 6:25 A M, from the causes and on the date stated above.

22a. SIGNATURE: Tillman D. Johnson M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1-15-67
22c. PHYSICIAN'S NAME (Type): Tillman D Johnson M.D.
22d. ADDRESS: 123 Singerly Ave, Elkton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/18/67
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery
23d. LOCATION (City, town or county) (State): Havre de Grace, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. REC'D BY REGISTRAR DATE: JAN 30 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00617

CERTIFICATE OF DEATH

00620

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit
c. LENGTH OF STAY IN 1b 16 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 16 N. Main Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit 07.1
d. STREET ADDRESS 16 N. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Ada Middle: B. Last: Wintermoyer

4. DATE OF DEATH Month: January Day: 4, Year: 1967

5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/18/1875
9. AGE (In years last birthday) 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Vance Whittington(D)
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give wor or dotes of service) ----------
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address Md.
Robert L. Wintermoyer, Jr., Port Deposit

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 24hrs
443X
DUE TO (b) Arterio Sclerotic Cardio Vascular Disease — 10yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Hypertension — 10yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 3, 19[illegible], to 1-4, 1967, that (I) (we) last saw the deceased alive an 1-4 1967, and that death occurred at 11:40 M, fram causes and an the date stated abave.

22a. SIGNATURE G. H. Richards Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 1-5-67.
22c. PHYSICIAN'S NAME (Type) G. H. Richards, Jr., M.D.
22d. ADDRESS Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 1/7/67
23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
23d. LOCATION (City or Town) (County) (State) Shepherdstown, W. Va.

24. FUNERAL DIRECTOR Lee A. Patterson & Son ADDRESS Perryville, Md.
25a. REC'D BY REGISTRAR DATE JAN 9 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00619

CERTIFICATE OF DEATH

00621

1 (M)

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   c. LENGTH OF STAY IN 1b: 3 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: N.C. — b. COUNTY
   c. CITY OR TOWN (If outside carporate limits, write RURAL ond give neorest town): PURLEAR 70.3
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LINZIE — Middle: GREEN — Lost: Woodie

4. DATE OF DEATH: Month: Jan — Doy: 23 — Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-2-1881

9. AGE (In yeors lost birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (County & Stote, or foreign country): PURLEAR N.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JIMMIE WOODIE

14. MOTHER'S MAIDEN NAME: FERBIE WILCOX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: LINNIE H. WOODIE — Address: RD#2 ELKTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gram-negative pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
493X
DUE TO
(b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

2 Arteriosclerotic heart disease with poss infarction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify thot (I) (this hospitol) attended the deceased from 21 Jan, 1967, to 23 Jan, 1967, that (I) (we) last saw the deceased olive on 23 Jan 1967, and that deoth occurred at 7:00 AM, from couses and on the dote stoted above.

22a. SIGNATURE: Wallace Obenshain — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 23 Jan 67

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain °MD.

22d. ADDRESS: Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/23/67

23c. NAME OF CEMETERY OR CREMATORY: BOILING SPRINGS

23d. LOCATION (City or Town) (County) (Stote): PURLEAR N.C.

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: ELKTON, MD.

25a. REC'D BY REGISTRAR DATE: JAN 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2b Film #G386 3/1/67 PC

CERTIFICATE OF DEATH

00620 00622

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 Wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital Of Cecil County

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Rural Millington, Maryland 14.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: William — Last: Wright
4. DATE OF DEATH: Month: 1 — Day: 28 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/22/82
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Labor
10b. KIND OF BUSINESS OR INDUSTRY: Labor
11. BIRTHPLACE (County & State, or foreign country): Essex County Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Wright
14. MOTHER'S MAIDEN NAME: Martha Jardin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leonard Wright — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1-Week
571.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocarditis — 2-Years
DUE TO (c): Gastro-enteritis — 5- Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/11/, 1967, to 1/28/, 1967, that (I) (we) last saw the deceased alive on 1/28/ 1967, and that death occurred at 2:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: James L. Johnson
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/28/67
22c. PHYSICIAN'S NAME (Type): James L. Johnson M.D.
22d. ADDRESS: 245 East High St., Elkton, Cecil, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: Jan. 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Philadelphia, Penna.
23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME
ADDRESS: Donald R. Lee Elkton, Md.
25a. REC'D BY REGISTRAR DATE: FEB 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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